

PATIENT INFORMATION

Please answer all questions and sign the front and back pages

Patient legal name: _____
(last) (first) (middle)

Sex: male/female/ _____ **Date of birth:** day _____ month _____ year _____

Health care #: _____ **Province:** _____

Is this a Workers Compensation claim (WCB)?: yes no

Home address: _____

City: _____ **Province:** _____ **Postal code:** _____

Home phone: () _____ - _____ **Cell phone:** () _____ - _____

Work phone: () _____ - _____ **Email:** _____

Occupation: _____ **Employer:** _____

Emergency contact name: _____

Relationship: _____ **Phone #** (different than above): _____

Referring doctor (first and last name & location) or **none:** _____

Family doctor (first and last name & location) or **none:** _____

Optometrist (first and last name & location) or **none:** _____

Current medical conditions and medications (circle all conditions that apply or **none**):

high blood pressure	diabetes Type 1 Type 2	kidney disease	rheumatoid arthritis
high cholesterol	cancer (type)	lung disease	osteoarthritis
heart disease	thyroid disease	asthma COPD	smoking: (circle one)
Pentosan Polysulfate	Elmiron	Plaquenil	never current former

Prior medical history (circle all that apply or **none**):

stroke (year)	heart attack (year)	cancer (type)	kidney failure (year)
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Other medical conditions (please list or **none**): _____

Medications and supplements (please list all or provide list or **none**): _____

Surgical history (please list all surgeries or **none**): _____

Allergies (please list or **none**): _____

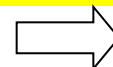
I verify that the above information is true and accurate to the best of my knowledge:

Signature: _____
(patient or legal representative, if applicable or if patient is under 18)

Printed name: _____

Date: _____

CONTINUED ON PAGE 2 – please turn over



Please be aware that your picture will be taken for identification purposes, it will be kept strictly confidential in your chart.

Calgary Retina Consultants (CRC) are strongly committed to clinical vision research to further advance knowledge and treatment of eye disease in their patients. One method of research is to review patients' medical records by ophthalmologists and associated staff in order to:

- identify patients who might be eligible to participate in a given study approved by a research ethics committee (prospective studies) and
- identify patients and document findings for answering a given research question (retrospective studies).

Results from prospective and retrospective studies could be presented at research conferences and/or published in scientific medical journals with assurance that no personal identities (name, address, date of birth, Alberta Health Care number) will be disclosed.

To achieve this, we need your authorization to review your medical records:
Please complete the following section.

I, _____, (print your name)

☐ authorize ☐ refuse (check one) the CRC Physicians, their designates, and staff to review my medical records for prospective and retrospective studies. This consent is valid for the duration of my care as a patient at this practice unless I revoke my consent.

Sign: _____

Date: _____

Authorization to access your Alberta Netcare record, as needed:

Sign: _____

Date: _____

Authorization to release/receive your medical information to/from another physician for continuity of patient care:

☐ authorize ☐ refuse (check one)

Sign: _____

Date: _____

Revised Nov 2023